

ABSTRACT

SOCIAL WORK

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HEALTH CARE SEEKING BEHAVIOR IN AFRICAN AMERICAN MEN:
IMPLICATIONS FOR SOCIAL WORK PRACTICE
IN THE PREVENTION AND CONTROL OF SEXUALLY TRANSMITTED
DISEASES

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The purpose of this study was to conduct community-based formative research to explore the health care seeking behaviors of low income African American men. Systems Theory, with an ecological perspective, combined with the Health Belief Model was the framework used to guide the assessment to identify opportunities for social work practice in public health, that can contribute to the prevention and control of sexually transmitted diseases, including HIV. Sixty-seven African American men in Atlanta, Georgia, Chicago, Illinois, Dallas, Texas, and Philadelphia, Pennsylvania were interviewed during street-based encounters. The researcher found that a majority of the African American men valued their health, were concerned about their health status, and practiced health care seeking behaviors. Economic issues proved to be the primary barriers to health care seeking behaviors. Findings suggest that Systems Theory, with an ecological perspective, combined with the Health Belief Model is a useful framework for understanding and assessing the health care seeking behavior of African American men. The practice implications for social work in public health that emerged in the study are in the areas of clinical practice, community practice, and policy practice.

HEALTH CARE SEEKING BEHAVIOR IN AFRICAN AMERICAN MEN:
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IN THE PREVENTION AND CONTROL OF
SEXUALLY TRANSMITTED DISEASES

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CHAPTER I

INTRODUCTION

In 1992, Marian Wright Edelman, an internationally known children's advocate, wrote to her sons in the book The Measure of Our Success, "It is utterly exhausting being Black in America...There is no respite or escape from your badge of color."¹ In that same year, Richard Majors and Janet Mancini Billson, social scientists from the University of Wisconsin and Rhode Island College respectively, wrote that racism and discrimination have inflicted a variety of harsh injustices on African Americans in the United States, especially on African American males: "Being male and black has meant being psychologically castrated--rendered impotent in the economic, political, and social arenas that whites have historically dominated."² The following year Ellis Cose published The Rage of a Privileged Class, in which he began by saying, "Despite its very evident prosperity, much of America's black middle class is in excruciating pain."³

The persistent presence of racism against African Americans in American society has been well documented. Although African Americans did indeed make important and substantial social and economic gains, relative to white Americans, following the Civil

¹M.W. Edelman, The Measure of Our Success (New York, New York: HarperCollins Publishers, Inc., 1993), 23.

²R. Majors and J.M. Billson, Cool Pose: The Dilemmas of Black Manhood in America (New York, New York: Lexington Books, 1992), 1.

³E. Cose, The Rage of a Privileged Class, (New York, New York: HarperCollins Publishers, 1993), 1.

Rights Movement of the 1960's, these gains have not been universally experienced by all African Americans, nor have their benefits been universally felt in all areas of life. In its 1968 report to President Lyndon Johnson, the National Advisory Commission on Civil Disorders concluded that the nation was at that time moving towards two separate and unequal societies, one black and one white. Twenty-five years later, Thomas Laveist wrote: "More than two decades later there is reason to believe that we are no longer moving toward separation, but rather have arrived at the point where racial segregation has become an enduring feature of America's social arrangement."⁴ One of the areas in which there remains a significant gap between African Americans and white Americans is in the area of health.⁵

Statement of the Problem

The study of racial differences in health in American society has been dominated by a more genetic model that tends to argue that the genes determining race are linked to those determining health, and that the health of a population is largely decided by the biological constitution of the population. However, a more likely explanation may be that race is a societally constructed taxonomy that reflects the intersection of biological, cultural, socio-economic, political, and legal determinants, as well as racism; and that it is these larger social factors which actually affect health by influencing health practices,

⁴T.A. Laveist, "Segregation, Poverty, and Empowerment: Health Consequences for African Americans", The Milbank Quarterly, 71(1) (1993): 44.

⁵R.S. Cooper, "Health and the Social Status of Blacks in the United States", Annals of Epidemiology 3(2) (March 1993): 138.

psychosocial stress, environmental stress, psychosocial resources and medical care.⁶ In his study of black-white infant mortality data in New York City, Yankaur was the first to empirically link racial segregation and health status in 1950. He observed that infant mortality rates were highest in the most severely segregated black neighborhoods.⁷ Perhaps the harshest impact of this health gap is to be found among African American men, who have historically experienced reduced life expectancy in the U.S. In 1988 vital statistics data showed that the All-causes mortality rates for African American men were 70% higher than those of their white counterparts.⁸ In 1990, Thomas Parham and Roderick McDavis described a bleak prognosis for African American men in the United States. They cited a number of factors which serve to shorten the life expectancy of African American men in the U.S., among these factors was the African American male's physical health. In 1994 Gregory Pappas of the National Center for Health Statistics, Centers for Disease Control and Prevention wrote:

One of the most disturbing trends of the last decade is the increasing difference in the life expectancy between Blacks and Whites. Kochanek et al. have investigated the causes of death associated with this inequality; they have found that heart disease is the number one cause of death fueling the disparity.⁹

⁶"Race in the Health of America: Problems, Issues, and Directions", Morbidity Mortality Weekly Report 42(RR-10) (June 25, 1993): 9.

⁷T.A. Laveist, "Segregation, Poverty, and Empowerment: Health Consequences for African Americans", The Milbank Quarterly, 71(1) (1993): 45.

⁸R.S. Cooper, "Health and the Social Status of Blacks in the United States", Annals of Epidemiology 3(2) (March 1993): 138.

⁹G. Pappas, "Elucidating the Relationships Between Race, Socioeconomic Status, and Health", American Journal of Public Health, 84(6), (June 1994): 892.

African American men are often subjected to inadequate health care, either through lack of facilities or because they under-utilize existing health care services.¹⁰ What then are the strategies needed to change Parham's and McDavis' grim predictions? What do African American men do to protect their health? How can they be assisted to seek health care services for primary prevention and early treatment?

The concept of health traditionally refers to the condition of being sound in body and mind, being free from physical disease or pain, or having a sense of well-being. However, the concept of health can differ across groups based upon a given group's overall position and place in the society. How does the African American male define "health"? What would he say is "well-being"? As an example, while many members of middle class America tend to seek preventive health care, thus preserving and in some cases perfecting physical health, a substantial number of working-class African Americans tend to see a doctor only when they experience symptoms that prevent them from being able to work. Symptoms which do not prevent the individual from going to work are often ignored by some disadvantaged African Americans, who often do not have employee health insurance or paid sick leave.¹¹ This kind of difference in the belief about when it is important to see a doctor can have critical impact upon health promotion and public health activities, particularly in the area of sexually transmitted disease control and

¹⁰T. Parham and R. McDavis, "Black Men an Endangered Species: Who's Pulling the Trigger?", Journal of Counseling and Development, 66 (September 1987): 24-27.

¹¹R.H. Hines, "Health Status of Black Americans: Changing Perspectives", Patients, Physicians, and Illness, E. Jaco, editor, (New York, New York: Free Press, 1972), 41-42.

prevention. Eric Bailey wrote that understanding the culture of an individual is of special importance in health related situations, because it determines whether an individual will utilize or avoid available health care services.¹² Social work practitioners have long understood the interrelatedness among the factors of social environment, social class, culture, and social problems of persons. This understanding is essential to grapple with the health problems found among African American men.

In 1930 among the principal causes of mortality in African Americans was epidemic and endemic infectious diseases, including influenza and syphilis. By 1960 the situation had seen little change,¹³ and the current U.S. epidemics of sexually transmitted diseases, including human immunodeficiency virus (HIV), continue to pose serious challenges to America's public health, especially in economically disadvantaged African American communities. Public health surveillance data from 1986 to 1990 showed that the national incidence of primary and secondary syphilis had increased by 77%. This was the highest rate since 1949.¹⁴ As they were declining among other racial and ethnic groups, in 1992, syphilis rates among African Americans remained 11 times higher than

¹²E.J. Bailey, "Sociocultural Factors and Health Care-Seeking Behavior Among Black Americans", Journal of the National Medical Association, 79(4) (1987): 389.

¹³R.H. Hines, "The Health Status of Black Americans: Changing Perspectives", Patients, Physicians, and Illness, E. Jaco, editor, (New York, New York: Free Press, 1972), 44.

¹⁴R.T. Rolfs and G. Schmid, "The United States Syphilis Epidemic: Reasons for Optimism (At Least for the Moment)", New York State Journal of Medicine, 91(12) (1991): 522.

those for Hispanics, and almost 62 times higher than those for whites.¹⁵ Congenital syphilis cases also increased in the late 1980's and early 1990's, resulting in significant morbidity and mortality rates among American children, most of whom were African American.¹⁶ Although national rates for gonorrhea have been declining since 1975, the rates among African Americans remained 40-fold higher than those for whites and 15 fold higher than those for Hispanics.¹⁷ Drug addiction, most notably the use of smokable crack-cocaine and injectable drugs, has been closely linked to the increase of sexually transmitted diseases, particularly syphilis and HIV infection.¹⁸ In 1993, researchers reported that African American heterosexual men and women were 10 times more likely to be diagnosed with Acquired Immunodeficiency Syndrome (AIDS) than were white heterosexual men and women, largely as a result of HIV transmission among injection drug users.¹⁹

¹⁵K.E. Toomey, "Epidemiological Considerations of Sexually Transmitted Diseases in Underserved Populations", Infectious Disease Clinics of North America 7(4) (December 1993): 740.

¹⁶W. Cates and G. Schmid, "Prevention Crucial as STDs Evolve", U.S. Medicine, (1990): 43-46.

¹⁷T.C. Quinn and W. Cates, "Epidemiology of Sexually Transmitted Diseases in the 1990s", Sexually Transmitted Diseases (1992): 5-6.

¹⁸A.A. Ernst and D.H. Martin, "High Syphilis Rates Among Cocaine Abusers Identified in an Emergency Department", Sexually Transmitted Diseases, (March-April 1993): 66.

¹⁹J.L. Peterson, "Multiple Sexual Partners Among Blacks in High-Risk Cities", Family Planning Perspectives, 25(6), (December 1993): 263.

The inability of private and government public health efforts to effectively prevent and control the spread of STDs in many communities, especially those that are poor and African American, constitutes a fundamental social, health, and welfare problem. As was illustrated in a recent study conducted by the Harvard School of Public Health, significant numbers of African Americans rate health care services in their communities as inadequate.²⁰ People, a disproportionate number of whom are often African American and male, are getting sick, and in growing numbers dying, from diseases that are either preventable or curable. In January 1995 the Centers for Disease Control and Prevention announced that HIV/AIDS had become the number one killer of persons between the ages of 25 and 44 years.

HIV, the cause of AIDS, however, is neither the first nor the only sexually transmitted infection that can result in death.²¹ In men gonorrhea and chlamydia are often asymptomatic, but in women, these same infections, left untreated, often progress to a complication called pelvic inflammatory disease. This condition can result in ectopic pregnancy, infertility, and death. The late complications of untreated syphilis can also end in death. Research has linked female cervical cancer to the human papillomavirus (HPV) infection, again a sexually transmitted infection that is often asymptomatic in

²⁰R. Blendon, "How White and African Americans View Their Health and Social Problems", Journal of the American Medical Association, 273(4) (January 1995): 345.

²¹U.S. Department of Health and Human Services, PHS, Centers for Disease Control and Prevention, NCPS, Division of Sexually Transmitted Diseases and HIV Prevention, Annual Report, (Atlanta, Georgia: United States Department of Health and Human Services, 1993).

males. Scientists believe that HPV infection may be the most prevalent STD in the U.S.²²

The disenfranchised and impoverished populations most vulnerable to the AIDS epidemic's 'second wave' often experience social prejudice, lack of access to adequate health care, limited socio-political power, and few social structures that are able to support behavioral risk reduction and health promotion.²³

African American women, may generally experience better quality of health and longer life expectancy rates than their male counterparts. They may also appear to have better access to health care. Yet clearly the evidence suggests that in the realm of sexually transmitted disease prevention their access advantage may be diminished, even erased, when their male partners do not have similar access.^{24 25}

A recent survey of African American leaders identified as one of their top public health goals the prevention and control of STDs and HIV,²⁶ but many African Americans frequently report profound distrust of government statistics that indicate disproportionate

²²S.O. Aral and K.K. Holmes, "Sexually Transmitted Disease in the AIDS Era", Scientific American, 264, (1991): 62-69.

²³J.A. Kelly, "Psychological Interventions to Prevent HIV Infection Are Urgently Needed: New Priorities for Behavioral Research in the Second Decade of AIDS," American Psychologist, 48(10), (1993): 1024.

²⁴S.O. Aral, et al., "Sex Partner Recruitment as Risk Factor for STD: Clustering of Risky Modes", Sexually Transmitted Diseases, 18(1), (1991): 10.

²⁵S.N. Seidman and S.O. Aral, "Subpopulation Differentials in STD Transmission", American Journal of Public Health, 82(9) (September 1992): 1297.

²⁶D. Schneider, M. Greenberg, and D. Choi, "Black Leaders' Perceptions of the Year 2000 Public Health Goals for Black Americans", American Journal of Public Health, 83(8), (1993): 1171.

STD and HIV rates within their communities. They argue that these kind of data suggest that African Americans are sexually promiscuous and irresponsible, historical characterizations that have been used by whites to justify racial discrimination. Indeed, some researchers have suggested that there may be reporting bias on the part of public health medical providers, who tend to see poorer patients. In a recent epidemiological article, Toomey and her co-authors wrote that disease reporting of private providers is thought to be less complete when compared to public-sector providers.²⁷

Despite the issues associated with reporting artifact, it is evident that the epidemics of sexually transmitted diseases, including HIV, pose a significant health problem for African Americans. The primary purpose of public health agencies is to protect and to promote the public's health. African American males are a part of that public. Although much of the focus during the current health care debate has been about personal health care, public health must also be a part of the discussion.

Whether historical advances against infectious diseases or contemporary gains against heart disease which have been dramatic in the last 20 years are assessed, the greatest improvements in health status have been derived from public health approaches, not from increased expenditures for medical care.²⁸

The implications for social work practice in the public health setting are significant. If the current public health care system is indeed unable to effectively respond to the

²⁷K.E. Toomey, "Epidemiological Considerations of Sexually Transmitted Diseases in Underserved Populations", Infectious Diseases Clinics of North America, 7(4), (1993): 741.

²⁸P.R. Lee and K.E. Toomey, "Epidemiology in Public Health in the Era of Health Care Reform", Public Health Reports, 109(1), (1994): 3.

needs of disadvantaged African Americans, and African American males in particular, then the skills of social workers in the areas of needs assessment, community organization, advocacy, and program design and implementation are greatly needed in the public health setting. Also because autonomous social work practice is seldom independent of the effects of public policy, social workers may need to act as public health policy practitioners as well.²⁹

As the debate over the type and scope of health care reform continues, it is crucial for social workers who practice in low-income African American communities to actively participate. Social workers have long worked with the most disenfranchised and disadvantaged groups in American society. Given his current state in America today, the indigent African American male is arguably among the most disenfranchised and disadvantaged.

Purpose of the Study

The purpose of this study was to conduct community-based formative research to explore the health care seeking behaviors of low income African American men. Utilizing a framework that combined Systems Theory, with an ecological perspective, and the Health Belief Model to guide the assessment, the researcher sought to identify opportunities for social work practice in public health that can contribute to the prevention and control of sexually transmitted diseases, including HIV. In addition to exploring when the African American male thinks it is important to see a doctor, the

²⁹B.S. Jansson, Social Welfare Policy: From Theory to Practice, (Pacific Grove, California: Brooks/Cole Publishing Company, 1990), 2.

researcher also asked if the cost of health care is associated with health care seeking behavior, and where does the African American male usually go for health care services? What are his perceptions of treatment in the health care setting? The researcher also investigated the definition of "healthy" from the African American male's perspective, and sought to explore under what circumstances he might self-treat. Finally, African American men were asked whom they consulted regarding health related issues.

Given the possible public health consequences of continued failure to prevent and control the spread of sexually transmitted diseases, primary prevention, and early diagnosis and treatment are critical.

CHAPTER II

REVIEW OF RELATED RESEARCH

The African American community, has had a long and complex history with the public health infrastructure. Thomas and Quinn found that to enhance public health intervention effectiveness for the purposes of HIV prevention, public health professionals must recognize how the history of slavery and racism in the U.S. has contributed to the current social [and physical] environments of African Americans living today. Those who are at greatest risk for STDs and HIV remain those persons who are also among the most disadvantaged members of the American society.¹ In 1989, Braithwaite and Lythcott wrote that poverty and powerlessness can create circumstances in the lives of disadvantaged persons that often predispose them to the highest indexes of social dysfunction, the highest indexes of morbidity and mortality, the lowest access to primary care, and little or no access to primary preventive programs.² David Williams, a Yale University researcher, found that the Black-White differences in essential hypertension were significantly linked to social and environmental factors. He wrote:

¹S.B. Thomas and S.C. Quinn, "Public Health Then and Now, The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV Education and AIDS Risk Education Programs in the Black Community", American Journal of Public Health, 81(11), (1991): 1498.

²R. Braithwaite and N. Lythcott, "Community Empowerment as a Strategy for Health Promotion for Black and Other Minority Populations", Journal of the American Medical Association, 261(2) (January 1989): 282.

If larger social processes and institutions are creating pathogenic environments and conditions, then attempts to reduce ill health among disadvantaged populations must extend beyond the curative approaches of clinical medicine and confront the macrosocial factors that affect the development, course, and differential distribution of disease.³

In making their argument for relevant sexuality education for African American youth, Pittman and a team of researchers identified specific African American male cultural experiences which must be considered in the design of sexuality educational interventions. Although often portrayed as "lazy, trifling, and jive", the authors wrote that African American males, like all men in the U.S., are socialized to evaluate their masculinity by their willingness to take risks, experience pain or discomfort and not submit to it, and by their drive to accumulate money, power, and sex partners.⁴ Several researchers have found that these kinds of cultural characteristics, as well as social prejudice, can have significant impact on the African American male's health care seeking behavior.⁵

Also influencing health care seeking behavior among African American males is the perception of treatment once they do enter a health care setting. African Americans

³D. Williams, "Black-White Differences in Blood Pressure: The Role of Social Factors", Ethnicity and Disease, 2, (1992): 126-138.

⁴K.J. Pittman, "Making Sexuality Education and Prevention Programs Relevant for African American Youth", Journal of School Health, 62(7) (September 1992): 340.

⁵E. Felder, "Baccalaureate and Associate Degree Student Nurses' Cultural Knowledge of and Attitudes Toward Black American Clients", Journal of Nursing Education, 29(6), (June 1990): 276.

are more likely to experience wait when they go for health care, as compared to whites.^{6 7}

In addition to waiting time as a factor, Blendon found that significantly more African American respondents, as compared to whites, reported not seeing a doctor within the year even when they also reported that their health status was fair or poor.⁸ As an example among those persons reporting that they had hypertension, 30% of the African American respondents, as compared to 19% of the white respondents, reported that they had not had an annual blood pressure check. The African American respondents were more likely than whites to report that during their last doctor visit, the physician did not inquire sufficiently about pain, did not tell them how long it would take for a prescribed medicine to work, did not explain the seriousness of the illness or injury, and did not discuss test or examination findings. Blendon also found that the African Americans were less likely to have any insurance coverage (85.1% of the African Americans as compared to 72.5% of the whites). Blendon concluded that the lack of parity in access to medical care between African American and whites resulted in substantially lower use of health services by African Americans.

⁶J.A. Roth, "Some Contingencies of the Moral Evaluation and Control of Clientele: The Case of Hospital Emergency Service", The Social Organization of Medical Care: A Critical Prospective, P. Conrad and R. Kern, editors, (New York, New York: St. Martin's Press, 1986), 322.

⁷N.L. Epstein, "Determinants of Regular Source of Health Care in Black, Mexican, Puerto Rican, and Non-Hispanic White Populations", Medical Care, 29(6), (June 1991): 543.

⁸R.J. Blendon, "Access to Medical Care for Black and White Americans: A Matter of Continuing Concern", Journal of the American Medical Association, 261(2), (January 1989): 278-281.

Although the incidence rate of sexually transmitted disease infection is high among African American men, much of the research around their health care seeking behavior is found primarily in the chronic disease prevention literature, particularly in the areas of hypertension and cancer prevention.^{9 10 11} In 1992 the cancer death rate among African Americans was 27% higher than that for the general population, a 50% increase in 30 years. For African American men alone, the rate represented a 77% increase.¹² Hypertension also remains among the leading causes of death among African Americans, and the incidence is highest among African American men.

In a study of African Americans' perceptions of cancer, conducted by the University of Toledo in Ohio, researchers surveyed 769 African American adults from 11 randomly selected churches in a Midwestern community. The mean age of the respondents was approximately 44 years. Twenty percent of the respondents said that testing for cancer was too expensive. One in six thought that being tested for cancer would take too much time. Approximately 20% of the respondents believed that doctors

⁹S.M. Underwood and E. Sanders, "Factors Contributing to Health Promotion Behaviors Among African American Men", Oncology Nursing Forum, 15(5), (1990): 707-712.

¹⁰D. Ballard, "Hypertension Control in a Rural Southern Community: Medical Care Process and Dropping Out", American Journal of Preventive Medicine 4(3) (1988): 133-139.

¹¹P.J. Bomar and M. Hautman, "Gender Differences in Health Practices of Black Couples with a Hypertensive Spouse", Journal of Human Hypertension, 4 (1990): 100-102.

¹²S.M. Underwood, "African American Men: Perceptual Determinants of Early Cancer Detection and Cancer Risk Reduction", Cancer Nursing, 14(6), (1991): 281-288.

would not tell the truth to patients who got cancer. Twenty percent also thought that hospital workers are not as friendly towards African Americans as they are to whites.

Although the majority of the study's respondents were female (n = 461), the researchers found important differences in the results among the males (n = 149) who participated in the study. Male respondents were significantly more likely than female respondents to believe that African Americans are more likely to develop cancer than whites (39% versus 29%). The researchers noted that there were no significant differences to this item based on the level of education or age of the respondents. The men also significantly believed that African Americans are more likely to die from cancer than are whites.¹³

In another recent cancer risk reduction study, conducted exclusively among African American males, whose mean education level was 14 years, Underwood found among the self-selected sample of 236, that 36% of the respondents believed that they were helpless in regard to health control. The researcher wrote, "The men within this group consistently expressed a belief that they had little or no control over their health status and that their health status was a matter of chance."¹⁴ Eighty-four percent of the sample thought that they were at great risk for developing cancer, but only 75% of those surveyed indicated that they believed that screening methods recommended by the

¹³J.H. Price, "Black Americans' Perceptions of Cancer: A Study Utilizing the Health Belief Model", Journal of the National Medical Association, 80(12), (1988): 1297-1304.

¹⁴S. Underwood, "Cancer Risk Reduction and Early Detection Behaviors Among Black Men: Focus on Learned Helplessness", Journal of Community Health Nursing, 9(1), (1992): 21.

American Cancer Society would improve their chances of survival. Finally, only 6% of the respondents thought that cancer deaths could be reduced by current cancer treatment, early cancer detection, and cancer risk reduction life style changes.¹⁵

In a 1990 Michigan blood pressure survey, researchers found that the poor health suffered by disadvantaged members of American society is not usually a consequence of their fundamental beliefs about health. Among a probability sample of 2,360 adults, the researchers found:

With few exceptions, the socially disadvantaged (lower socioeconomic and black respondents, in particular) were not characterized by attitudes which reflected a lack of concern about health or disregard for the value of medical care or healthy life styles.¹⁶

The researchers concluded that successful community health promotions directed towards the poor may need to address the structural barriers to good health which characterize social disadvantage.

Accessible effective STD treatment and prevention services are essential to slow and halt the growth of these epidemics. Local city and county health departments have traditionally been the public health agencies chiefly responsible for STD related services.

In a 1990 report prepared by the National Association of County Health Officials, the

¹⁵Ibid., 21.

¹⁶J.L. Weissfeld, J.P. Kirscht, and B.M. Brock, "Health Beliefs in a Population: The Michigan Blood Pressure Survey", Health Education Quarterly 17(2) (Summer 1990): 141-155.

authors wrote that there is "great diversity" among local health departments,¹⁷ suggesting that the quality and scope of STD services are subject to the same kind of variance as well.

Local health departments are expected to provide STD services within their catchment areas. In addition they are also usually required to respond to issues of environmental health, community health assessment, and other communicable disease surveillance and intervention. As early as 1935, with the passage of the Social Security Act, the federal government has assumed a more proactive role in public health. One of the earliest public health issues about which the federal government took action was the control of sexually transmitted diseases, then referred to as "venereal disease". The government's involvement in STD control and prevention increased dramatically over the next 30 years. In the late 1960's, the federal government began shifting its funding mechanisms to categorical grants in an effort to balance public health and other high priority national needs.

During the 1980's, the U.S. Public Health Service began to return much more of the financial responsibility for public health to the states, who in turn were forced to shift more of the burden to local authorities. Increasingly, counties and cities found that more services were required, as funding resources became less. Public health priorities

¹⁷National Association of County Health Officials, National Profile of Local Health Departments. (Washington, D.C.: National Association of County Health Officials, 1990).

competed, and ultimately it was local citizens, particularly those who were poor, who actually bore much of the burden by losing needed health services.

Late in the 1980's, the onset of the AIDS epidemic brought about a sudden rush to repair, and in some situations rebuild, a dismantled and decimated public health infrastructure to respond to the new health crisis. Because there is, to date, no cure for HIV infection, and AIDS is usually fatal, disease prevention became the primary objective of many public health efforts. The federal government increased funding to state and local health departments, and also began funding a variety of community-based organizations, to provide risk reduction services to populations at risk for HIV infection.

It was thought that community-based organizations would be more successful at reaching and educating those persons at high risk for HIV infection. The AIDS epidemic was regarded as a national emergency. While conventional strategies to prevent and control disease were deemed acceptable to address the common STDs, such as syphilis, the AIDS epidemic, according to many public health officials, warranted a novel, more innovative approach. Yet there remains a dearth of African American male health care seeking behavior research as it relates to sexually transmitted disease treatment and prevention.

Theoretical Framework

In social work, health care is increasingly discussed using Systems Theory with an ecological perspective. Systems Theory assumes a world-view that allows for more complexity and diversity. It represents a shift from ordering the world hierarchically to an emphasis on the interaction of influences, constraints, and interests. The universe is

seen as holographic rather than mechanistic. Direct causality as a concept gives way to the concept of mutual causality. Finally, Systems Theory moves from the notion that complex systems are simply the sum of their parts, and describes them as morphogenetic, that is to say, these systems become new forms.¹⁸ Systems Theory provides a means of thinking about relationships among entities. It is a way of organizing perceptions of various dynamic processes. Systems are regarded as organized wholes, and living systems are capable of and react to change.

The utilization of the ecological perspective emphasizes the importance of describing and conceptualizing an individual's social environment as it relates to his health status.¹⁹ The ecological perspective enables the social worker to better understand how processes within a client system occur. The ecological perspective assumes that:

- 1) individual behavior is best explained within the total environmental context,
- 2) human environments are extremely complex and include: physical, social, economic, and political structures, and
- 3) individuals must maintain an adaptive mutuality with their environments.

As a means of organizing this complex environment, in 1979, Bronfenbrenner proposed envisioning the environment as a nested arrangement of circumjacent contexts including:

¹⁸K. Ell and H. Northen, Families and Health Care: Psychosocial Practice, (New York, New York: Aldine de Gruyter, 1990), 2.

¹⁹D.R. Brown and L.E. Gary, "Stressful Life Events, Social Support Networks, and the Physical and Mental Health of Urban Black Adults", Journal of Human Stress, Winter, (1987): 165-174.

the microsystem or person, the mesosystem or interpersonal relations within family, school, and work contexts, the exosystem or social structures and institutions, and the macro system or over-arching cultural patterns, values, and ideologies.²⁰ Each of these contexts is thought to have effects on health and illness. Systems Theory with an ecological perspective is particularly cogent when it comes to the discussion of physically accessible and socially acceptable health care.

To focus more specifically on an individual's health care seeking behavior, social work practitioners may turn to more cognitive theories and models. One model commonly used to guide health promotion and health education programs is the Health Belief Model.²¹ The model has four basic tenets:

- 1) a person must believe that his health is in jeopardy,
- 2) a person must perceive the potential negative outcomes of a given condition (e.g. pain, lost time from work),
- 3) a person must believe that the benefits from practicing the health behavior are greater than the cost of practicing the health behavior, and that the action needed is within his ability, and
- 4) a person must perceive a cue to take action or otherwise experience a precipitating force that will cause him to take action.²²

Although the Health Belief Model is very useful for understanding health care seeking behavior among African American men, it is limited in that it does not tend to

²⁰K. Ell and H. Northen, Families and Health Care: Psychosocial Practice, (New York, New York: Aldine de Gruyter, 1990), 3.

²¹H.S. Ross and Paul Mico, Theory and Practice in Health Education (Palo Alto, California: Mayfield Publishing Company, 1980), 58-59.

²²M.W. Kersell and J.H. Milsum, "A Systems Model of Health Behavior Change", Behavioral Science, 30 (1985): 119-120.

fully address social normative beliefs and influences. It also does not clearly account for the impact of actual health status on health behavior or the accessibility and acceptability of health care services.

A number of studies have found that it is essential to understand an individual's health care seeking behavior within the context of his environment. Important and influential environmental factors may be better understood using Systems Theory with an ecological perspective. By combining Systems Theory with an ecological perspective, practitioners can enlarge the unit of attention to include the individual, his social institutions, his culture, and the interactions and transactions among and within his specific systems and sub-systems. A framework is provided in which to examine reciprocal processes between the person and his environment. These processes may include: interpersonal transactions, social support, coping behaviors, role-taking, social learning, resource acquisition, social stress, and the effects of social policies.

A theoretical framework that facilitates the explanation of the person within the full context of his environment may enable better understanding of health care seeking behavior among African American males. Systems Theory, with an ecological perspective, and the Health Belief Model can provide such a framework to the social worker in public health.

Statement of Research Questions

1. What does the African American male do to protect his health?
2. When does the African American male think it is important to see a doctor, under what circumstances would he self-treat, and is the cost of health care associated with his health care seeking behavior?

3. Where does the African American male usually go for general health care, and what are his perceptions of treatment in the health care setting?
4. How does the African American male define the concept of healthy?
5. With whom does he consult regarding health related issues?
6. What are the potential social work practice implications for STD prevention and control?

Definition of Terms

Culture: a patterned way of life that has special meaning to the individual and his or her social group.²³

Health: the physical and biological aspects of well-being.²⁴

Health Care Seeking: to seek information or services to protect, promote, or restore health.²⁵

Sexually Transmitted Disease (STD): an infection contracted during intimate physical contact between 2 persons.

²³E.J. Bailey, "Sociocultural Factors and Health Care-Seeking Behavior Among Black Americans", Journal of the National Medical Association, 79(4), (1987): 389.

²⁴R.H. Hines, "The Health Status of Black Americans: Changing Perspectives", Patients, Physicians, and Illness, E. Jaco, editor, (New York, New York: Free Press, 1972): 40.

²⁵K. Ell and H. Northen, Families and Health Care: Psychosocial Practice, New York, New York: Aldine de Gruyter, 1990), 25-29.

CHAPTER III

METHODOLOGY

Respondents and Setting

The data for this study was collected from low-income, disadvantaged, urban neighborhoods in four major metropolitan areas: Atlanta, Georgia, Chicago, Illinois, Dallas, Texas, and Philadelphia, Pennsylvania. These sites were selected for both convenience and demographics. The sample was a cross-sectional, non-probability, convenience sample, consisting primarily of low-income and working class, African American men, who were between the ages of 18-45 years. The research was conducted in the community. Interviewers approached and interviewed the men on the street. The sample size was 67.

Questionnaire Package

The instrument was comprised of two sections, reflecting factors identified in the existing health care seeking literature. The instrument contained 27 items. Section I (items 1-19) utilized quantitative, closed-ended questions that provided a descriptive profile of the respondents. Section II (items 20-27) was qualitative and utilized open-ended questions to allow for an ethnographic exploration of the factors related to health care seeking behavior. The instrument was reviewed by epidemiologists and behavioral scientists for content validity. The interviewers also pretested the instrument for readability and data recording purposes.

On the cover page of the instrument was an introduction to the survey that also included the study's statement of purpose. In the introduction, which was read to each respondent, the respondent was assured of both anonymity and confidentiality. Because the survey was completely anonymous and the interview was conducted outside formal or institutional settings, a consent form was not used. The complete instrument is included as the appendix.

Procedure

The survey was conducted between the dates of February 7 and February 28, 1995. The instrument was administered by agency interviewers, who had been previously trained in both qualitative and quantitative data collection methods. These persons also had substantial professional experience providing outreach to persons who have been traditionally defined as "hard to reach". In addition, these interviewers were also well-practiced in street-based interviewing techniques.

In three of the sites, Chicago, Dallas, and Philadelphia, the interviewers worked in mixed-gender teams of 2 to 4 persons. In Atlanta, the interviews were conducted by a single female. In Dallas and Atlanta the interviews were collected in one day. In Chicago and Philadelphia the interviews were collected over two days. The average length of time per interview was between 12-20 minutes.

Although the respondents were recruited on the street, the interviewers were able to provide a degree of privacy for each interview. On the cover page, the interviewer recorded the date of each interview, the city, his/her initials, and the start and finish time of the interview. The interviewers recorded the respondent's answers to the questions and

utilized the probes where provided. At the completion of the interview the interviewers also recorded any relevant comments about the interview process. The surveys were mailed to the investigator for quantitative and qualitative analysis and reporting.

CHAPTER IV

PRESENTATION OF RESULTS

Respondent Profile

Ninety-one percent of the 67 respondents described themselves as African American, 4.5% described themselves as African, 3% were Caribbean, and one respondent described himself as "Black". They ranged in age from 18 to 45 years, with a mean age of 33. Seventy percent were single, and the mean level of education for the group was 12 years. Approximately 57% were employed while 43% reported that they did not have a job. Of those who were employed, 64.3% said that they did have sick leave from their jobs. More than 86% of the men described their health condition as either good or excellent. Eleven men reported having a chronic health condition, and 63.7% of these 11 men cited high blood pressure as their ailment.

Almost 42% of the group indicated that they had health insurance. Table 1 depicts employment status by health by health insurance, and shows that for this group of men being employed was associated with having health insurance. Respondents who reported having insurance were significantly more likely to have a job than those who did not have insurance (Chi Square=29.59, df=65, $p < .001$).

Table 1.--Employment Status by Health Insurance

Insurance	Employment	No Employment	Total
YES	23	5	28
NO	6	33	39
Total	29	38	67

Although more than 58% of the group did not have health insurance, a slight majority of the men stated that they do usually go to a private doctor (37.3%) for general health care. Approximately 34% reported going to either a community clinic or public health clinic for general health care services. Table 2 presents the frequency distribution of the respondents' last visit to the doctor. This table shows that a majority of the respondents reported seeing a doctor within the last year.

Table 2.--Frequency Distribution of Last Visit to the Doctor

Timing	N	%
This Month	16	23.9
This Year	37	55.2
< 5 Years	10	14.9
> 5 Years	4	6.0

Most, 91%, of the respondents indicated that they had been treated well or excellent the last time they went to see a doctor. Table 3 depicts the preferred sources of health care for sexual health, and shows that the respondents appeared to prefer a public provider

(e.g. community clinic, public health clinic, or hospital) for sexual health care services.

Single table analysis revealed that the obvious preference was also statistically significant (Chi Square=37.16, df=65, $p < .001$).

Table 3.--Frequency Distribution of Sources of Sexual Health Care

Source	N	%
Private Doctor	25	37.3
Public Health Clinic	15	22.4
Community Clinic	12	17.9
Hospital/Emergency Room	12	17.9
Other	3	4.5
Total	67	100

Ninety-eight percent of the respondents reported having sexual intercourse. The mean number of sexual partners for the men was 5, however, one respondent did report having had 100 sexual partners in the past year. Most of the men reported having 1 to 2 sexual partners. Approximately 42% of the 67 respondents reported having had a sexually transmitted disease (STD). Only one person stated that he had not received treatment for his STD, and one other respondent indicated not knowing or being unsure that he had received treatment. Table 4 presents the frequency of condom use, and shows that over 46% of the men said that they used condoms either all the time or regularly, but the mean response for condom use was occasionally.

Table 4.--Frequency of Condom Use

Use	N	%
All the Time	22	33.8
Regularly	8	12.3
Occasionally	18	27.7
Not at All	16	24.6
Don't Know	1	1.5

Table 5 provides a comparison of tobacco, alcohol, and drug use among the 67 respondents. Most of respondents had smoked at least occasionally in the last year (55.2%). Slightly more than 34% said that they smoked all the time. Approximately 31% said that within the last year they drank alcohol either all the time or regularly. Almost 69% said that they drank only occasionally or not at all. Slightly more than 25% said that they had used drugs other than alcohol all the time within the past year. Approximately 48% of the men reported that they used drugs other than alcohol at least occasionally.

Table 5.--Frequency Distribution of Tobacco, Alcohol, and Drug Use

Frequency	Tobacco		Alcohol		Drug Use	
	N	%	N	%	N	%
All the Time	23	34.3	11	16.4	17	25.4
Regularly	6	9	10	14.9	4	6
Occasionally	8	11.9	32	47.8	11	16.4
Not at All	30	44.8	14	20.9	35	52.2
Don't Know	0	0	0	0	0	0

The majority of the 67 respondents (71.6%) had never been in drug treatment, as compared to 28.4% who had. Of those who had been in drug treatment (n=19), approximately 37% had been in drug treatment 3 or more times.

Most of the respondents said that they discussed health issues with either a health care provider or a family member. Others said that they talked to no one about health issues, and others reported that they would talk to anyone who would listen. Finally, one person said that he talked to God.

Definition of Healthy

The respondents regularly defined healthy from both physical and mental perspectives. They also often described a state of being to define healthy. Table 6 gives a summary of the responses.

Table 6.--Definitions of Healthy

Physical	Mental	State of Being
"Fit."	"Well being of mind and soul."	"Long life."
"Strength."	"Mental stability."	"Doing good for myself."
"Body well-being."	"Mental and spiritual balance."	"It means a lot."
"Good physical condition."	"Emotional stability."	"My life will be excellent with God's reach."
"Not being sick all the time."	"Being in a good frame of mind."	"The Lord has spared me another day."
"Feeling good. Being able to carry out daily activities without any problems."	"To have my ability to think."	"Alive."
"Not being on prescription drugs."		"Living well."
"Being functional [and] able to get around."		"Life."
"Means being able to do what I used to do."		"Means I'm fine."
"Proper weight and exercise."		"To keep going or living."
"Drug free, smoking free, alcohol free."		"To take care of myself."
"Waking up without being tired or feeling any ailments."		"Being healthy means everything to me. Without your health you have nothing."
Waking up feeling great without pain."		"To not have AIDS and able to work a job."
		"It means everything, not to need a helping hand to get around."

Things Done to Take Care of Health

When describing their health protection, respondents discussed both physical and mental health. Eating right and exercising was cited most frequently. Responses included:

- "Lift weights."
- "Eat correct. No red meat. Habitual behavior, exercise 3 times a week."
- "Try to eat a balanced diet. I don't most of the time."
- "Cook with no salt."

Other respondents included sexual intercourse as part of their health protecting behaviors:

- "Eat properly and exercise daily, have healthy and safe sex."
- "Have lots of sex."

Many respondents linked health protecting activities to drug use:

- "Don't do drugs. Use prevention."
- "Go to detox and take vitamins."
- "Eat and smoke my drugs so I can feel good."
- "Work-out, eat good, and stay away from drug spots."

Some of the men also noted that getting regular check-ups, taking prescribed medications, as well, as vitamins and Geritol, was a means of protecting their health.

To protect mental health, some respondents listed: going to church and stress reduction. "Don't worry," one respondent said.

When to See the Doctor

Most of the respondents said that it would be important to see a doctor when they were either sick or ill. Similarly, others said that it would be important to see a doctor when they experienced pain or symptoms:

- "When I don't feel well."
- "When I have symptoms of something wrong."

- "Real sick, not cured with over the counter medicine."
- "[When your] body tells you. When I feel irregular."
- "When I'm feeling real bad or hurting."
- "If I had persistent pain."

Although some respondents also indicated that they would consider it important to see a doctor only in a life threatening situation, "If I get deathly sick", others suggested concern about primary prevention:

- "Every three months for a check-up."
- "Every six months."
- "Once a year."
- "Go get a check-up."

Most of the respondents did not report that they had self-treated. Those that did usually self-treated for colds, headaches, and influenza. However, a few of the men did state that they had self-treated for more serious illness and injuries, "I had pneumonia. I ate soup, rested and prayed." Another respondent described using white Dial soap lather to treat deep cuts on his knee and finger that he had received during a fight. He later learned that these wounds required skin grafts. There were a few respondents who also reported self-treating bone fractures.

Barriers to Health Care

The respondents reported not having enough money as the primary barrier to health care services. They often described the cost of medical care, inadequate or no insurance, and unemployment as having a combined effect that limited their ability to access health care:

- "Not able to afford."
- "High cost of medical treatment."
- "The cost of co-payments."

- "Before working it was difficult because of the cost."
- "If I don't have a job."
- "Not having proper insurance."

Some respondents also listed access issues (e.g., distance, clinic hours, and waiting for services) among the barriers they experienced to health care:

- "Transportation, hospital too far from my home or job."
- "Call for appointments, not going straight in."
- "Waiting to be seen, long lines, one doctor on staff."
- "The health care system itself. Three months waiting for an access card."

One respondent described finding a good doctor as a barrier. Another said, the "VA" (Veterans Hospital) was a barrier. Another respondent, a smoker, said, "Age as one gets older, and smoking [because] insurance companies consider smokers at high risk."

Still other respondents reported that their primary barriers to health care included fear and denial, "[I'm] afraid of what I might find out about myself."

Discrimination

Although most of the respondents described treatment during their last visit to the doctor as being good or excellent, some also reported that they had experienced discrimination in the health care setting. Some attributed the perceived discrimination to their ethnicity:

- "I received poor treatment because I'm black."
- "African American men [are] only targeted for the wrong reasons, just to turn around information and make them look bad."

Others thought that they were discriminated against in the health care setting because they were either poor or did not have health insurance:

- "[You are] not good enough, looked down upon."
- "I was treated differently because I didn't have insurance."

Those who reported experiencing discrimination were also more likely to report using drugs.

- "[They] think I might be here to steal."
- "They treat you like a dog when they know you are a dope fiend."
- "If you [use] drugs and being addicted, they always give me something for my illness that I can't sell, like cough syrup or down pills."
- "Once they know you're on drugs they discriminate."

Facilitators to Health Care

Many respondents reported that they did not experience barriers to accessing health care services. One respondent said about barriers to health care, "Nothing. I go to the doctor regular." Another said, "I go all the time." The majority of respondents listed among potential facilitators to health care: lower health care cost, having a better job, having insurance/better insurance, and having money:

- "Cheaper cost."
- "More free clinics."
- "More jobs."
- "Insurance on the job."
- "A job and health insurance."
- "Free insurance."
- "If I had a job at company with health insurance."

The men also said that health care facilities closer to their communities would facilitate access. They also cited more convenient clinic hours and shorter waits for service. One man said, "If the doctor would come to my house."

Some respondents also indicated that access to health care was influenced by issues of ethnicity. One respondent said, "[If the] government would stop lying to us blacks." Another said, that in addition to not having to make appointments, "more black doctors and nurses" would facilitate his access to health care.

CHAPTER V

SUMMARY AND CONCLUSIONS

The majority of the African American men who participated in this study valued their health, were concerned about their health status, sought to protect it, and reported health care seeking behaviors. Most seemed to understand health-protecting, and health care seeking behavior as a personal behavior, or as microsystemic. Their health-protecting and health care seeking behaviors were also compatible with the basic tenets of the Health Belief Model. Often despite having limited resources and encountering multiple cultural and structural barriers (exosystemic and macrosystemic), slightly more than 79% of the group reported having been to the doctor within the last year. Approximately 42% had had a sexually transmitted disease, and 93% of these men had received treatment for their infections. To protect their health the men most frequently talked about diet and exercise. They said it was important to get regular check-ups and take vitamins. They also mentioned that not using drugs would protect their health; and some talked about stress reduction and even going to church.

Overwhelmingly the men thought that it would be important to see the doctor when they felt sick or had symptoms. Some said that they would see the doctor only when they were deathly sick or in a life threatening situation, and only a few reported self-treating for serious illnesses or injuries.

In this study, economics (exosystemic) proved to be the primary barrier to health care seeking behavior. The men said that not having a job, not having insurance, simply

not having money made it harder for them to access health care services. The majority were unemployed, and the majority were uninsured.

Although they reported not having adequate financial resources for health care, a slight majority of the respondents said that they went to a private doctor to meet their general health care needs, and again, most of them had visited a medical provider within the last year. The private doctor was equal to family members when it came to whom the men talked to about health issues, a mesosystemic factor. After a private provider, the men were most likely to go to a public health clinic or community clinic for services. Interestingly, for sexual health related services the men preferred a public health clinic or community clinic.

This group of African American men defined healthy from both mental and physical perspectives. They talked about being physically fit and mentally stable. Among the group there was significant concern about being functional and being able to get around. One respondent said that for him healthy meant being able to do what he used to do. To be functional also had mental implications, as one respondent put it, being healthy meant, "To have my ability to think." For some being healthy just meant that they were not sick all the time. To be healthy simply meant that they could wake up without feeling tired or having pain.

Often the men described being healthy as kind of a state of being. For some of the men religion or spirituality was an important part of their state of being. "My life will be excellent with God's reach." "The Lord has spared me another day." For others to be healthy meant that they were alive. Some said that healthy was taking care themselves or

doing good for themselves. One respondent said that healthy for him was, "To not have AIDS and able to work a job."

While the majority of the African American men who participated in this study described their health status as good or excellent, the overall health status of African American men represents a persistent social and public health problem. The economic, social, and political gains made by African Americans since the Civil Rights Movement have not been experienced by all. Perhaps there are indeed two societies in the U.S. Some researchers have described a phenomenon called "biculturalism".¹ The concept is used to explain the ability to function in two worlds. Ziter wrote that biculturalism is an important part of the African American experience. She stated that African Americans must negotiate between two cultures: one African American and nurturing and one white and hostile. She argued that social and behavioral intervention activities with African Americans must include 3 primary considerations:

- 1) a clear perspective on the meaning of the African American experience
- 2) the isolation of the behavioral components among African Americans that have fostered their survival, and
- 3) the implications of counseling in a racist society.²

There may also be cultural implications based on poverty and substance abuse which effect health care seeking behavior. A number of the respondents attributed the negative

¹M.L.P. Ziter, "Culturally Sensitive Treatment of Black Alcoholic Families", Social Work, (March-April 1987): 131.

²Ibid., 131.

way they were treated in the health care setting to their drug use or to not having insurance.

Clearly the African American experience in the United States is a complex one. This complexity can have significant effect upon the health status and health care seeking behavior of African American males. It is important then for health professionals to understand more thoroughly the interrelatedness between these men and their environments.

Limitations of the Study

The small sample size and demographic composition was one of the limitations of this study. It is recommended that future studies use larger and more diverse samples. Although the respondents were from multiple regions of the country, because each group was so small and subject to convenience sampling, the findings from this study cannot be generalized to all African American men.

Another limitation of this study was the length of the interviews. The interviews on average lasted 12-20 minutes, and the brevity may have limited the depth of answers that could be obtained from the respondents.

Suggestions for Future Research

Existing health care seeking behavior research among African American males tend towards chronic diseases such as cancer and hypertension. Future studies in this area among this group should investigate health care seeking behavior as it relates to sexually transmitted diseases including HIV infection. The health care seeking behavioral factors associated with sexually transmitted diseases may be unique to this public health problem.

The men in this study preferred private providers over public providers for their general health care, yet for sexual health care they preferred the public provider to the private provider. Future studies should explore more thoroughly the factors associated with choosing a health care provider.

Because economic issues were the most frequently cited barriers to health care, future studies should provide comparison groups of low-income men from other ethnic groups (e.g. whites, Hispanics, Asians), as this may reveal that the findings in this study are more associated with socio-economic class than they are associated with ethnicity.

Finally qualitative research is an important means of collecting data about social and cultural factors related to health care seeking behavior. It is recommended that future studies be designed to encourage and allow for longer interviewing encounters with respondents.

CHAPTER VI

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Public health concerns are not new to the field of social work. As early as the settlement house movement, social workers have been involved in public health. Both the social work and public health professions are committed to the well-being of both the individual and the community.¹ In general the helping relationship, characteristic of social work intervention is well suited to public health practice.² Recently several joint programs for MSW-MPH degrees have been established at universities throughout the U.S. The social work approach to public health prevention is related to the practice modalities and methods that originally emerged during the first several decades of this century. The profession has moved from a more general direct practice approach to encompass community practice and health education.

The traditional public health model usually combines an ecological, multi-causal, and interactive framework to assess public health problems and develop interventions. The model tends to be organized in terms of three categories of interactive influence: the individual, the agent (the source of illness or disability), and the social and physical environment.³ It assumes that health-related events occur as a result of reciprocal and

¹G. Rosen, "Public Health: Then and Now: Social and Health Problems Are Inseparable", American Journal of Public Health, 61(11), (November 1971): 2311-2312.

²D. H. Hepworth and Jo Ann Larsen, Direct Social Work Practice (Pacific Grove, California: Brooks/Cole Publishing Company, 1993) 31.

³K. Ell and Helen Northen, Families and Health Care: Psychosocial Practice (New York: Aldine de Gruyter, 1990), 102.

dynamic relationships among multiple factors. Systems Theory with an ecological perspective, so familiar to social workers, expanded by the tenets of the Health Belief Model, can result in an orientation that is highly compatible with the traditional public health model.

The African American male represents a microsystem, and generally he is also a part of multiple mesosystems. These mesosystems are in turn within the context of social structures and culture, the exosystems and macrosystems respectively. Findings from this study suggest that to effectively deliver health promotion and health care services to low income and working class African American men, professionals working in public health will need to conduct comprehensive needs assessments that are attentive to these multiple systems. Additionally, they will need to develop theory-guided interventions. Systems Theory, with an ecological perspective, combined with the Health Belief Model can be useful for understanding the health care seeking behaviors of African American men. This kind of framework broadens the unit of attention, and can help to prioritize client needs and problems, identify appropriate strategies, and facilitate service delivery. The framework may also provide a foundation upon which to build important process and outcome evaluations.

While many of the potential interventions for STD prevention and control may be at the exosystem level: public health policy planning and formulation, and STD program planning, administration, and implementation,⁴ social work skills are also very

⁴Gene Hooyman, Robert W. Schwanke, and Helen Yesner, "Public Health Social Work: A Training Model", Social Work in Health Care, 6(2), (1980): 87.

applicable at the micro- and mesosystem level, or what is commonly known as clinical practice.⁵ Social workers are especially adept at working with persons in the areas of: assessment, and goal directed intervention planning and implementation, and evaluation.⁶ These can be critical skills for promoting health, reducing risk behaviors, and increasing access to health care.⁷ Social workers can provide individual risk reduction counseling, partner notification services, and also assist clients in developing healthier sexual relationships with their partners. However, it is important to note that findings from this study suggest that it may be very crucial to move practice skills beyond the walls of institutions and access persons in their own environments.

As public health departments increasingly rely upon behavioral interventions to implement STD prevention and improve control, professionals knowledgeable of behavioral science theory will be required to design and deliver public health services.⁸ Clinical social work practice in STD control and prevention with African American males can include:

- 1) case finding and development of guidance for initial interaction with persons,

⁵Diana Tendler and Karen Metzger, "Training in Prevention: An Educational Model for Social Work Students", Social Work in Health Care, 4(2), (1978): 222.

⁶D. H. Hepworth and J. Larsen, Direct Social Work Practice: Theory and Skills, (Chicago, Illinois: The Dorsey Press, 1986), 26.

⁷J. F. Loomis, "Case Management in Health Care", Health and Social Work, (Summer 1988): 219-225.

⁸K. Ell and Helen Northen, Families and Health Care: Psychosocial Practice (New York: Aldine de Gruyter, 1990), 101.

- 2) explication of social and educational approaches for assisting persons to respond to changing demands within their environment, and
- 3) examination and implementation of feasible and desirable patterns of interdisciplinary collaboration on behalf of clients.⁹

There is also a role for the community practitioner in the prevention and control of sexually transmitted diseases including HIV. Community practice social workers can organize entire disadvantaged African American neighborhoods to respond collectively to disease outbreaks in their communities.^{10 11} A community practice social worker could organize groups to advocate for the establishment of a neighborhood clinic. As another example, a community practice social worker could mobilize a group to lobby for the hours of an existing health clinic to be changed so that they are more accessible to working persons. A number of the respondents in this study reported that their access to health care was limited due to distance, lack of transportation, and clinic hours of operation. Many of the respondents indicated that although employed, they did not have sick leave benefits. Because some sexually transmitted diseases are asymptomatic in males, taking time off from work and losing a day's pay to get a medical examination or

⁹D. Tendler and K. Metzger, "Training in Prevention: An Educational Model for Social Work Students", Social Work in Health Care, 4(2), (1978): 222.

¹⁰Fred M. Cox, John L. Erlich, Jack Rothman, and John E. Tropman, Tactics and Techniques of Community Practice (Itasca, Illinois: F.E. Peacock Publishers, Inc., 1984): 49-55.

¹¹Christine L. Young, "Family Planning Utilization by Black and White Women: Public Health Social Work Implications", Social Work in Health Care, 13(2), (1987): 106.

even treatment, when one is not experiencing any pain or discomfort, could be perceived as simply too costly, even if one does have health insurance or the service is free.

Historically public health professionals have relied upon data from four major sources: vital statistics, medical records, health surveys, and epidemiological investigations.¹² More recently public health researchers have moved towards the inclusion of qualitative data in the assessment process to more fully describe the context of health-influencing factors. Social workers can bring an important skill to this area since the client interview is an essential element of qualitative data collection. As was seen in this study, the use of qualitative interviewing techniques by public health professionals, can serve to enhance communication with African American communities, and with African American males in particular. This study may suggest that a short quantitative and qualitative interview, conducted with African American men in their own environments, can provide valuable information about their health related behaviors. The range of responses revealed that the men had a variety of ideas, concerns and recommendations that might have been otherwise missed using an exclusively close-ended survey in a formal or institutional setting. Although no monetary incentive was offered to the respondents they were nevertheless quite willing to be interviewed. Perhaps the incentive was simply being given an opportunity to express their opinions about issues that they deemed important.

¹²Ibid., 102.

Public health agencies at the state and local levels are assuming increasing responsibility for meeting the basic medical and preventive health care needs of people, who are frequently without other access to direct medical services.¹³ Sexually transmitted diseases, including HIV, represent a growing social, health, and welfare problem for many disadvantaged American communities. From clinical practice with clients at risk of contracting sexually transmitted infections, to community organization and mobilization, and policy practice, that involves personal and public health care reform, social workers in public health can make important contributions towards the development of solutions that facilitate health care seeking behavior among African American men, and thereby improve the prevention and control of sexually transmitted diseases within this group.

¹³P. R. Lee and K. Toomey, "Epidemiology in Public Health in the Era of Health Care Reform", Public Health Reports, 109(1), (1994): 1.

APPENDIX

Appendix

HEALTH CARE-SEEKING BEHAVIOR INTERVIEW

Date: _____

City: _____

Interviewer's Initials: _____

Time Started: _____

Time Finished: _____

INTRODUCTION:

Thank you for agreeing to participate in this survey. The information that you provide is confidential. The survey is anonymous, and your name will not be asked.

Your comments will provide helpful information in identifying important health care-seeking issues for African American men, between the ages of 18 and 40, who live in urban settings. Thank you again for your vital participation.

SECTION I

1. How old are you? ____
2. Which of the following ethnic groups do you belong to?
 - 1 African American
 - 2 Caribbean American
 - 3 African
 - 4 Other _____
3. What is the last grade of school that you completed? ____
4. Do you currently have a job?
 - 1 Yes
 - 2 No

If yes, do you get paid sick-leave?

 - 1 Yes
 - 2 No
5. Do you have health insurance?
 - 1 Yes
 - 2 No
6. Are you presently:
 - 1 Single
 - 2 Married or living with someone
7. Which one of the words below best describes your health condition?
 - 1 Excellent
 - 2 Good
 - 3 Bad
 - 4 Terrible
 - 5 Other _____

8. Do you have any chronic health problems (such as high blood pressure, heart disease, arthritis)?

1 Yes
2 No
3 Don't Know/Not Sure

If yes, what is it? _____

9. Where would you go for **sexual** health care services?

1 Private Doctor
2 Public Health Clinic
3 Community Clinic
4 Hospital/Emergency Room
5 Other _____

10. Have you ever had a sexually transmitted disease?

1 Yes
2 No
3 Don't Know/Not Sure

If yes, were you treated?

1 Yes
2 No
3 Don't Know/Not Sure

11. Where do you *usually* go for **general** health care?

1 Private Doctor
2 Public Health Clinic
3 Community Clinic
4 Hospital/Emergency Room
5 VA Hospital
6 No Source

12. When was the last time you went to the doctor for treatment/check-up?
- 1 During this month
 - 2 In the last year
 - 4 In the last five years
 - 5 More than 5 years ago
 - 6 Never
13. The last time you went to the doctor how would you say you were treated in the health care setting? (Example: "Were people polite to you?")
- 1 Excellent
 - 2 Good
 - 3 Bad
 - 4 Terrible
 - 5 Other_____
14. Have you ever had sexual intercourse?
- 1 Yes
 - 2 No
- If yes, how many sexual partners have you had in the past year?__
15. When you have sex how often do you use a condom?
- 1 All the time
 - 2 Regularly
 - 3 Occasionally
 - 4 Not at all
 - 5 Don't Know/Not Sure
16. During the past year, did you smoke cigarettes?
- 1 All the time
 - 2 Regularly
 - 3 Occasionally
 - 4 Not at all
 - 5 Don't know

17. During the past year, did you drink alcohol?

- 1 All the time
- 2 Regularly
- 3 Occasionally
- 4 Not at all
- 5 Don't know

18. During the past year have you used any kind of drugs (such as marijuana, heroin, cocaine, crack cocaine, etc.)?

- 1 All the time
- 2 Regularly
- 3 Occasionally
- 4 Not at all
- 5 Don't know

19. Have you ever been in a drug treatment program (such as a methadone program, a drug-free outpatient treatment program, residential program or detox)?

- 1 Yes
- 2 No

If yes, how many times? ____

SECTION II

20. What does it mean to be "**Healthy**" to you?
21. What kinds of things do you do to take care of your health?
22. Who do you talk to about your health concerns/problems?
23. When would it be important for you to go see a doctor?
24. In the last year, have you ever self-treated yourself for any illness--*excluding headaches, colds and flu*?

1 Yes
2 No

If yes, please describe:
25. What kinds of things make it hard for you to get health care?
(Probe: For sexually transmitted diseases?)

26. Have you ever felt discriminated against in the health care setting?

1 Yes

2 No

If yes, please describe:

27. What would make it easier for you to get general health care? (Probe: For sexually transmitted diseases?)

Thank you very much.

Interviewer Comments:

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